

**California Healthy Families**  
**Vision Rate Development for Contract Year July 2005 through June 2006**

Instructions

**Prepare a separate projection for each Healthy Families Product. Highlighted cells containing certain key calculations are locked and cannot be modified.**

**Schedule 1:** If applicable, provide historical utilization and costs for your Healthy Families Program (HFP) population by region, and for the state as a whole if your product is in more than one region. Provisions for incurred but not reported (IBNR) claims should be included in the reported figures, as appropriate. For each category of service, please provide the following:

- 1) Please provide the Healthy Families member months for the data period. This information is used in the calculated fields to derive the "Annual Utilization rate per 1,000 members" **[Column D]** and the "Gross Cost Per Unit of Service" **[Column E]**.
- 2) **Column A:** A description of what the unit counts represent (for example, visits, claims, units of service).
- 3) **Column B:** The Total Cost by vision service.
- 4) **Column C:** The Total Unit Count by vision service.
- 5) **Column D - Calculated Field:** The annual utilization rate per 1,000 members. This is calculated as units of service provided during the data period divided by the member months for the data period multiplied by 12,000.
- 6) **Column E - Calculated Field:** The Gross Cost per Unit of Service. This is calculated as total costs of service **[Column B]** divided by the total units of service **[Column C]** provided during the data period.
- 7) **Column F:** The Average Copay per Unit of Service. This should be calculated as the total copayments collected divided by the total units of service, within each category of service.
- 8) **Column G - Calculated Field:** The Net Cost Per Unit of Service. This is calculated as the "Gross Cost per Unit" **[Column E]** minus the "Copay per Unit" **[Column F]**.
- 9) **Column H - Calculated Field:** The Cost per Member per Month (PMPM). This is calculated by multiplying the "Annual Utilization Rate per 1,000 members" **[Column D]** and the "Net Cost per Unit" **[Column G]** and dividing the results by 12,000.
- 10) **Column G:** The percentage of enrollees receiving service during the year.

Please also provide, on a per member per month basis, the costs for:

- 1) Capitation payments to providers.
  - 2) Provider incentive payments.
  - 3) The net cost of reinsurance. This equals reinsurance premiums less reinsurance recoveries. The figures in the detail lines should be reported before reinsurance recoveries are taken into account.
  - 4) Utilization management and quality assurance (UM/QA) costs.
- Please also provide the HFP member months for the data period. The remainder of the values are automatically calculated.

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**Schedule 2:** Using experience from the HFP provide projected trends and other adjustments for your HFP population by region. For 2005-2006, plans new to the HFP within the past 2 years should skip to Schedule 3B.

1) Enter your expected annual utilization and unit cost trend rates from the data period through the 2005-2006 contract period. For example, if you project Restorative utilization will decrease by 5% per year and unit costs will increase by 10% per year, enter -5 and 10 in the Utilization and Unit Cost columns, respectively. The annual trend rate for per member per month costs is automatically calculated). The trend factors (the amount by which your reported experience will be adjusted for trend are also automatically calculated. If the appropriate number of trend months is different than 24, please enter the correct number and provide an explanation for the difference. The number of trend months should be from the midpoint of the experience period to the midpoint of the contract period (1/1/2006). Also, please provide an explanation of the source of your trend assumptions in the space provided.

2) As appropriate, enter any additional adjustment factors to be applied to project historical costs to the contract period. These factors will be automatically applied to the historical utilization rates to produce the projected utilization in Schedule 3A. Provide a brief description of the reason for the adjustments next to the factor. Further space is provided at the bottom of the schedule if necessary to adequately describe the nature of the adjustments.

**Schedule 3A:** This schedule develops the expected 2005-2006 vision care costs for the HFP population in each region. If Healthy Families experience was reported in Schedule 1, Schedule 3A is automatically populated using the reported experience and the assumptions in Schedule 2. If experience other than Healthy Families is being used, perform the cost projections using Schedule 3B.

**Schedule 3B:** Complete this schedule only if your plan was new to HFP within the past two years. You may use data other than HFP experience for the rate development process. Identify the data source for the utilization and cost assumptions. As in Schedule 1, enter the utilization, unit cost, and copayment assumptions in columns (A), (B), (C), (F). Columns (D), (E), (G), (H) are calculated fields. The unadjusted vision care cost will be automatically calculated.

**Schedule 4:** Report administrative costs per member per month for the HFP in the categories shown. Enter your projected vision care costs from Schedule 3A or Schedule 3B, as appropriate. Schedule 4 calculates your rate bid as the sum of the administrative costs and the projected vision care costs.

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**Schedules 5 and 6:** Complete the loss ratio report. For current HFP plans, the expenses reported on Line 11 (TOTAL VISION) of Schedule 6 should be equivalent to the Total Vision Care Expenditures calculated at the bottom of Schedule 1.

For vision plans submitting information for multiple regions, the Schedules 5 and 6 submitted should be a consolidation for all regions. Also, this Schedule 5 and 6 should be in the workbook for the first region that your plan is submitting a bid for (ie. If your plan is submitting a bid for Regions 1 through 6, then the consolidated Schedule 5 and 6, will be in the workbook for Region 1).

**Schedule 7:** Fill out this schedule if your loss ratio is below your contractual level. The schedule asks for an explanation if the loss ratio is below the contractual level and for a description of the methods you intend to use to reach your target loss ratio.

**Schedule 8:** This is a presentation of your rate projection and must equal the prices on Schedule 4.

**Schedule 9:** List number of members by payor (Medical vs Other).

**Schedule 10:** Provide a certification by your vision plan's actuary that the experience for 2003-2004 is accurate and that the assumptions used to project costs during the contract period are reasonable.

**Submit Schedules 1 through 10 via e-mail to Stuart Busby, Financial Operations Officer ([sbusby@mrmib.ca.gov](mailto:sbusby@mrmib.ca.gov)). Mail a signed hard copy of Schedule 10 (Actuarial Certification) to Stuart Busby c/o MRMIB, 1000 G St. Suite 450, Sacramento, CA 95814. All documents must be received by 5 p.m. January 6, 2005.**

# Schedule 1

**California Healthy Families**  
**July 2005 - June 2006 Rate Development**  
**Utilization and Cost Experience July 2003 through June 2004**  
 Fill out one for each Region and Statewide (if applicable)

Plan Name \_\_\_\_\_

(Specify Region or Statewide) \_\_\_\_\_

HFP Member Months July 2003 - June 2004

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)
	Description of Units (e.g., days, claims, units of service)	Total Cost	Total Units	Annual Units per 1000 Members	Gross Cost per Unit	Copay per Unit	Net Cost per Unit	Cost PMPM	Percent of enrollees receiving service during the year
Vision Services									
Exams					\$ -		\$ -	\$ -	0.0%
Frame & Lenses					\$ -		\$ -	\$ -	0.0%
Contact Lenses					\$ -		\$ -	\$ -	0.0%
Other Services					\$ -		\$ -	\$ -	0.0%
Capitation								\$ -	
Provider Incentive Payments								\$ -	
Net Reinsurance Costs								\$ -	
UM/QA Costs								\$ -	
Total including Provider Incentive Payments								\$ -	
Total excluding Provider Incentive Payments								\$ -	
Total Vision Care Expenditures								\$ -	

# Schedule 2

## California Healthy Families

### July 2005 - June 2006 Rate Development

#### Assumptions Used to Project Costs for July 2005 - June 2006

Fill out one for each Region

Plan Name \_\_\_\_\_

Specify Region \_\_\_\_\_

Months of Trend (should be 24 if data from 2003/2004 contract year used as the base):

24

If different than 24, please explain: \_\_\_\_\_

#### Vision Services

Annualized Trend Rates			Trend Factors			Other Adjustments	
Utilization	Unit Cost	PMPM	Utilization	Unit Cost	PMPM	Factors	Description
		0.00%	1.000	1.000	1.000	1.000	
		0.00%	1.000	1.000	1.000	1.000	
		0.00%	1.000	1.000	1.000	1.000	
		0.00%	1.000	1.000	1.000	1.000	
					1.000	1.000	
					1.000	1.000	
					1.000	1.000	
					1.000	1.000	

Source of trend assumptions:

\_\_\_\_\_

Other Adjustments:

\_\_\_\_\_

# Schedule 3A

**California Healthy Families**  
**July 2005 - June 2006 Rate Development**  
**Projected Vision Care Costs for July 2005 - June 2006**  
**Based on Healthy Families Experience Projection**  
 Fill out one for each Region

Plan Name \_\_\_\_\_

Specify Region \_\_\_\_\_

	(A)	(B)	(C)	(D)	(E)
Vision Services	Annual Units per 1000 Members	Gross Cost per Unit	Copay per Unit	Net Cost per Unit	Cost PMPM
Exams		\$ -	\$ -	\$ -	\$ -
Frame & Lenses		\$ -	\$ -	\$ -	\$ -
Contact Lenses		\$ -	\$ -	\$ -	\$ -
Other Services		\$ -	\$ -	\$ -	\$ -
Capitation					\$ -
Provider Incentive Payments					\$ -
Net Reinsurance Costs					\$ -
UM/QA Costs					\$ -
Total including Provider Incentive Payments					\$ -
Total excluding Provider Incentive Payments					\$ -

**GO ON TO SCHEDULE 3B**

# Schedule 3B

**Projected costs for July 2005 - 2006**  
**July 2005 - June 2006 Rate Development**  
**Projected Vision Care Costs for July 2005 - June 2006**  
**New Plans (in Healthy Families Program 2 years or less)**  
Fill out one for each Region

Plan Name \_\_\_\_\_

Specify Region \_\_\_\_\_

Data source for developing assumptions [e.g., Commercial, Other (describe)]: \_\_\_\_\_

HFP Member Months July 2003 - June 2004

**Vision Services**

	(A) Description of Units (e.g., days, claims, units of service)	(B) Total Costs	(C) Total Units	(D) Annual Units per 1000 Members	(E) Gross Cost per Unit	(F) Copay per Unit	(G) Net Cost per Unit	(H) Cost PMPM
Exams					\$ -		\$ -	\$ -
Frame & Lenses					\$ -		\$ -	\$ -
Contact Lenses					\$ -		\$ -	\$ -
Other Services					\$ -		\$ -	\$ -
Capitation								\$ -
Provider Incentive Payments								\$ -
Net Reinsurance Costs								\$ -
UM/QA Costs								\$ -
Total								\$ -
Adjustment for California Children's Services								\$ -
Total after adjustments								\$ -
Total vision expenditures costs after adjustments								\$ -

# Schedule 4

**California Healthy Families**  
**July 2005 - June 2006 Rate Development**  
**Projected costs for July 2005 - June 2006**  
**Administrative Costs and Rate Bid**  
 Fill out one for each Region

Plan Name \_\_\_\_\_

Specify Region \_\_\_\_\_

**Administrative costs**

Claims processing, data processing, customer service  
 General administrative overhead  
 Marketing: Communication, education, printing  
 Provider contracting, managed care network maintenance  
 Risk charges (identify) \_\_\_\_\_  
 Profit  
 Other (identify) \_\_\_\_\_

Total administrative costs

Total vision care costs from Schedule 3A or 3B

Rate projection ( total per member per month premium)

Cost PMPM	Percent of premium
\$ -	0.00%
\$ -	0.00%
\$ -	0.00%
\$ -	0.00%
\$ -	0.00%
\$ -	0.00%
\$ -	0.00%
\$ -	0.00%
\$ -	0.00%
\$ -	0.00%
\$ -	0.00%



## Schedule 5

### HEALTHY FAMILIES PROGRAM July 2005 - June 2006 Rate Development 7/03 - 6/04 LOSS RATIO REPORT

Plan Name \_\_\_\_\_

Did your plan have a minimum 1,000 HFP enrolled subscribers per month for six or more months in the July 03 - June 04 benefit year?

Yes

No


**NOTE: All Plans, regardless of enrollment must complete the loss ratio report.**

Total \$ amount of covered benefits for services provided to HFP subscribers from 7/1/03 - 6/30/04 \*

\$	-
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Total \$ amount of premiums received from the state for HFP subscribers from 7/1/03 - 6/30/04 \*\*

\$	-
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Total \$ amount received as incentive payment from 7/1/03-6/30/04 \*\*\*

\$	-
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Healthy Families Program 7/1/03 - 6/30/04 Benefit Year Actual Loss Ratio including Incentive Payments

**(Sch. 6: (Item 11 PLUS Item 4) DIVIDED by Item 1 = (Item 11+ Item 4) / Item 1)**

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Healthy Families Program 7/1/03 - 6/30/04 Benefit Year Actual Loss Ratio excluding Incentive Payments

**(Sch. 6: Item 11 DIVIDED by Item 1 = Item 11 / Item 1)**

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Healthy Families Program 7/1/03 - 6/30/04 Benefit Year Minimum Loss Ratio in Contract

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Difference between Actual Loss Ratio including Incentive Payments above  
and Minimum Loss Ratio in Contract (Over / (Under))

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Difference between Actual Loss Ratio excluding Incentive Payments above  
and Minimum Loss Ratio in Contract (Over / (Under))

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\* Total from Item # **11** on the Statement of Revenue and Expenses Report, Schedule 6

\*\* Total from Item # **1** on the Statement of Revenue and Expenses Report, Schedule 6

\*\*\* Total from Item # **4** on the Statement of Revenue and Expenses Report Schedule 6

If your plan's **Actual Loss Ratio** is lower than the **Minimum Loss Ratio in Contract**, complete the Loss Ratio Description Schedule 7

# Schedule 6

## HEALTHY FAMILIES PROGRAM 2003-2004 LOSS RATIO REPORT STATEMENT OF REVENUE AND EXPENSES

Plan Name \_\_\_\_\_ Healthy Families Benefit Year  
July 1, 2003 - June 30, 2004

SUBSCRIBER MONTHS (Healthy Families Program subscribers only) \_\_\_\_\_

### REVENUES: (Healthy Families Program only)

1. Premium Payments from State	\$ -
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### AFFILIATED ENTRIES AND NONAFFILIATED ENTRIES:

2. Incentive Payments to affiliated parties	\$ -
3. Incentive Payments by to nonaffiliated parties	\$ -
4. Total Incentive Payments	\$ -

### EXPENSES: (Healthy Families Program only)

#### Vision Services:

5. Exams	\$ -
6. Frames & Lenses	\$ -
7. Contact Lenses	\$ -
8. Other Services	\$ -
9. Reinsurance Expenses	\$ -
10. Incentive Pool Adjustment	\$ -
11. TOTAL VISION SERVICES (Line 5 to Line 10)	\$ -

#### Administration:

12. Compensation	\$ -
13. Interest Expense	\$ -
14. Occupancy, Depreciation and Amortization	\$ -
15. Management Fees	\$ -
16. Marketing	\$ -
17. Affiliate Administration Services	\$ -
18. Aggregate Write-ins for Other Administration Expenses	\$ -
19. TOTAL ADMINISTRATION (Line 12 to Line 18)	\$ -
20. TOTAL EXPENSES (Line 4, Line 11, & Line 19)	\$ -
21. INCOME (LOSS) (Line 1 less Line 20)	\$ -
22. Extraordinary Item	\$ -
23. Provision for Taxes	\$ -
24. NET INCOME (LOSS) (Line 21 plus Line 22 & Line 23)	\$ -

Line 11 TOTAL VISION EXPENSE	\$ -
Schedule 1 Total Vision Care Expenditures	\$ -
Difference	\$ -

Explain any difference: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HEALTHY FAMILIES PROGRAM 2003-2004 LOSS RATIO REPORT**

Plan Name \_\_\_\_\_

If your plan's Actual Loss Ratio is lower than your Minimum Loss Ratio in Contract, provide a detailed response explaining 1) why the actual loss ratio was significantly below the contractual standard and 2) plans you have to assure the Board that future loss ratios will be consistent with the contractual standard agreed to in your contract. Please respond to the following specific questions. Your response can be provided in a separate file if you prefer.

1. Why is your company's actual loss ratio substantially lower than the projected value for the 2003-2004 benefit year?

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2. How do your HFP provider payments compare to your contractual payments in:

- The MediCal Program?
- Commercial products?
- The payment schedules set forth in the Medicare program?

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3. How does your company's HFP utilization experience in each of the service categories compare to your company's children's utilization experience in:

- The MediCal Program?
- Commercial products?

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4. Does your plan offer providers any type of "end of year" payment incentive program? If so, please describe. Include in your description any differences in the allocation of incentive payments to affiliated and non-affiliated groups or other distinctions in how incentive payments are made by group.

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5. What does your plan do to encourage families to seek out and utilize preventive services? Do you have plans to improve provider's behavior with regard to providing and reporting appropriate preventive care visits? If so, please describe.

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6. Are there other factors that explain your plan's low loss ratio? If yes, please describe.

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7. What are the methods you will use to reach your target loss ratio?  
When would you expect that to occur?

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Schedule 8

Healthy Families Program  
Contract No. \_\_\_\_\_

Confidential Attachment  
Rates of Payment  
Page \_\_\_\_ of \_\_\_\_

**PREMIUM RATES**

Premium Rates for the July 1, 2005 - June 30, 2006 benefit year.

Note: Bid should match the figure shown in Schedule 4.

	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per Subscriber age 1 to 18 years of age						

## Schedule 9

**HEALTHY FAMILIES PROGRAM**  
**July 2005 - June 2006 Rate Development**  
**Number of Members for Dec 31, 2003 and Dec 31, 2004**

Plan Name: \_\_\_\_\_  
Contract No.: \_\_\_\_\_  
Contact Person & Phone Number for Follow-Up: \_\_\_\_\_

Payor	As of 12/31/2003		As of 12/31/2004	
	Subscribers	Subscribers and Dependents	Subscribers	Subscribers and Dependents
Medi-Cal				
All California Business				

**California Healthy Families  
July 2005 - June 2006 Rate Development  
Projected costs for July 2005 - June 2006 and Loss Ratio Report  
Certification of Claims Experience and Cost Projections**

Plan Name \_\_\_\_\_

I certify that the claims experience and cost projections are accurate and appropriate for the California Healthy Families Program.

By: \_\_\_\_\_  
Print name Date  
  
\_\_\_\_\_  
Signature & Title Phone number